



Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC.# 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>190</u>	Skilled (SNF)	<u>190</u>	<u>69,540</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>190</u>	TOTALS	<u>190</u>	<u>69,540</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>18,679</u>	<u>549</u>	<u>3,880</u>	<u>23,108</u>	8
9	SNF/PED					9
10	ICF	<u>34,445</u>	<u>1,511</u>	<u>169</u>	<u>36,125</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>53,124</u>	<u>2,060</u>	<u>4,049</u>	<u>59,233</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 85.18%D. How many bed-hold days during this year were paid by Public Aid?  
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒I. On what date did you start providing long term care at this location?  
Date started 05/15/77

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number  
of beds certified 36 and days of care provided 3,458Medicare Intermediary MUTUAL OF OMAHA

## IV. ACCOUNTING BASIS

MODIFIED  
ACCRUAL ☒ CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31/00

\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number AMBASSADOR NURSING & REHABILIT/ # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
1	Dietary	279,188	46,579	17,638	343,405		343,405	10,289	353,694			1
2	Food Purchase		276,568		276,568	(41,548)	235,020	(96)	234,924			2
3	Housekeeping	198,494	36,695		235,189		235,189		235,189			3
4	Laundry	63,801	29,624		93,425		93,425		93,425			4
5	Heat and Other Utilities			129,847	129,847		129,847	1,544	131,391			5
6	Maintenance	35,966		134,702	170,668		170,668	(22,509)	148,159			6
7	Other (specify):*							2,356	2,356			7
8	<b>TOTAL General Services</b>	577,449	389,466	282,187	1,249,102	(41,548)	1,207,554	(8,416)	1,199,138			8
9	<b>B. Health Care and Programs</b>											
9	Medical Director			1,650	1,650		1,650		1,650			9
10	Nursing and Medical Records	1,686,746	51,748	583,191	2,321,685		2,321,685	(4,481)	2,317,204			10
10a	Therapy	79,254	66,458	9,985	155,697		155,697	(1,446)	154,251			10a
11	Activities	130,261	6,449	3,901	140,611		140,611		140,611			11
12	Social Services	45,986		9,876	55,862		55,862		55,862			12
13	Nurse Aide Training			360	360		360		360			13
14	Program Transportation											14
15	Other (specify):*							4,790	4,790			15
16	<b>TOTAL Health Care and Programs</b>	1,942,247	124,655	608,963	2,675,865		2,675,865	(1,137)	2,674,728			16
17	<b>C. General Administration</b>											
17	Administrative	188,465		63,310	251,775		251,775	125,300	377,075			17
18	Directors Fees											18
19	Professional Services			615,006	615,006		615,006	(420,956)	194,050			19
20	Dues, Fees, Subscriptions & Promotions			116,265	116,265		116,265	(54,666)	61,599			20
21	Clerical & General Office Expenses	162,691	58,996	202,941	424,628		424,628	(26,876)	397,752			21
22	Employee Benefits & Payroll Taxes			498,593	498,593	41,548	540,141		540,141			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,070	3,070		3,070	670	3,740			24
25	Other Admin. Staff Transportation			652	652		652	2,059	2,711			25
26	Insurance-Prop.Liab.Malpractice			117,207	117,207		117,207	81	117,288			26
27	Other (specify):*							33,979	33,979			27
28	<b>TOTAL General Administration</b>	351,156	58,996	1,617,044	2,027,196	41,548	2,068,744	(340,409)	1,728,335			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,870,852	573,117	2,508,194	5,952,163		5,952,163	(349,962)	5,602,201			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

AMBASSADOR NURSING & REHABILITATION CENTER, INC.

0004077

COST REPORT RECLASSIFICATIONS

01/01/00

12/31/00

SCHEDULE V  
LINE #

22	EMPLOYEE BENEFITS	41,548	
2	FOOD		41,548

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		
19	PROFESSIONAL FEES		

To reclass cost of appealing real estate taxes

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			102,389	102,389		102,389	53,480	155,869			30
31	Amortization of Pre-Op. & Org.			5,000	5,000		5,000	4,362	9,362			31
32	Interest			105,409	105,409		105,409	136,267	241,676			32
33	Real Estate Taxes			207,047	207,047		207,047		207,047			33
34	Rent-Facility & Grounds			173,356	173,356		173,356	(159,982)	13,374			34
35	Rent-Equipment & Vehicles			18,135	18,135		18,135	1,606	19,741			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			611,336	611,336		611,336	35,733	647,069			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		138,248	386,100	524,348		524,348	(70,873)	453,475			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			104,310	104,310		104,310		104,310			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		138,248	490,410	628,658		628,658	(70,873)	557,785			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,870,852	711,365	3,609,940	7,192,157		7,192,157	(385,102)	6,807,055			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **AMBASSADOR NURSING & REHABILITATION CEN # 0004077**Report Period Beginning: **01/01/00**Ending: **12/31/00****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	<b>NON-ALLOWABLE EXPENSES</b>	<b>Amount</b>	<b>Refer- ence</b>	<b>OHF USE ONLY</b>	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(28,397)	30		9
10	Interest and Other Investment Income	(3,320)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(96)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(2,340)	21		18
19	Entertainment				19
20	Contributions	(1,900)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(107,278)	21		24
25	Fund Raising, Advertising and Promotional	(54,396)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(4,184)	20		28
29	Other-Attach Schedule	(95,445)			29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (297,356)		\$	30

<b>OHF USE ONLY</b>							
48		49		50		51	
						52	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1	2	
		<b>Amount</b>	<b>Reference</b>	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(87,746)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (87,746)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (385,102)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.**

		1	2	3	4	
		<b>Yes</b>	<b>No</b>	<b>Amount</b>	<b>Reference</b>	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0004077  
Report Period Beginning: 01/01/00  
Ending: 12/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch, V Line Reference
1	Deferred Maintenance	\$	6 1
2	TRUST FEES	(385)	21 2
3	BANK CHARGES	(45,973)	21 3
4	STATE REPLACEMENT TAX	(1,000)	21 4
5	CAPITALIZED PAINTING & DECORATING	(993)	6 5
6	CAPITALIZED REPAIR & MAINTENANCE	(28,133)	6 6
7	IL COUNCIL, LLC - NON ALLOW	(274)	21 7
8	PRIOR YEAR LEGAL SERVICES	(766)	19 8
9	MARKETING CONSULTANT	(17,921)	19 9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
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74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(95,445)	90

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTE

#

0004077

Report Period Beginning:

01/01/00

Ending:

12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary				363		9,926						10,289	1
2	Food Purchase	(96)											(96)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,544									1,544	5
6	Maintenance	(29,126)		528	6,089								(22,509)	6
7	Other (specify):*				2,356								2,356	7
8	<b>TOTAL General Services</b>	<b>(29,222)</b>		<b>2,072</b>	<b>8,808</b>		<b>9,926</b>						<b>(8,416)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records			29,840			(34,321)						(4,481)	10
10a	Therapy					(1,446)							(1,446)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			4,790									4,790	15
16	<b>TOTAL Health Care and Programs</b>			<b>34,630</b>		<b>(1,446)</b>	<b>(34,321)</b>						<b>(1,137)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative			125,300									125,300	17
18	Directors Fees													18
19	Professional Services	(18,687)	980	(403,249)									(420,956)	19
20	Fees, Subscriptions & Promotions	(58,580)		3,914									(54,666)	20
21	Clerical & General Office Expenses	(159,150)	3,186	129,088									(26,876)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			670									670	24
25	Other Admin. Staff Transportation			2,059									2,059	25
26	Insurance-Prop.Liab.Malpractice			81									81	26
27	Other (specify):*			33,979									33,979	27
28	<b>TOTAL General Administration</b>	<b>(236,417)</b>	<b>4,166</b>	<b>(108,158)</b>									<b>(340,409)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(265,639)</b>	<b>4,166</b>	<b>(71,456)</b>	<b>8,808</b>	<b>(1,446)</b>	<b>(24,395)</b>						<b>(349,962)</b>	<b>29</b>

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTI # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	(28,397)	57,148	24,729									53,480	30
31	Amortization of Pre-Op. & Org.		4,362										4,362	31
32	Interest	(3,320)	133,270	6,317									136,267	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(173,356)	13,374									(159,982)	34
35	Rent-Equipment & Vehicles			1,606									1,606	35
36	Other (specify):*													36
37	<b>TOTAL Ownership</b>	(31,717)	21,424	46,026									35,733	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers					(62,116)	(8,757)						(70,873)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>					(62,116)	(8,757)						(70,873)	44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	(297,356)	25,590	(25,430)	8,808	(63,562)	(33,152)						(385,102)	45

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Chaya H. Meisels Trust A	50.00%	SEE ATTACHED		SEE ATTACHED		
L& R Meisels Family Trust No. 2	50.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	34	RENT	\$ 173,356	AMBASSADOR BLDG. PARTNERSHIP		\$	(173,356)	1
2	V	32	INTEREST - MORTGAGE		AMBASSADOR BLDG. PARTNERSHIP		133,270	133,270	2
3	V	19	ACCOUNTING FEES		AMBASSADOR BLDG. PARTNERSHIP		980	980	3
4	V	31	AMORTIZATION EXPENSE		AMBASSADOR BLDG. PARTNERSHIP		4,362	4,362	4
5	V	30	DEPRECIATION EXPENSE		AMBASSADOR BLDG. PARTNERSHIP		57,148	57,148	5
6	V	21	OFFICE EXPENSE		AMBASSADOR BLDG. PARTNERSHIP		3,186	3,186	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 173,356			\$ 198,946	\$ * 25,590	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	QUALITY CARE MANAGEMENT	100.00%	\$ 1,544	\$ 1,544
16	V	6 REPAIRS AND MAINT.		QUALITY CARE MANAGEMENT	100.00%	528	528
17	V	10 SAL-NURSING		QUALITY CARE MANAGEMENT	100.00%	29,840	29,840
18	V	15 EMP. BEN.-H.C.		QUALITY CARE MANAGEMENT	100.00%	4,790	4,790
19	V	17 ADMIN SAL-NON-OWNER		QUALITY CARE MANAGEMENT	100.00%	5,396	5,396
20	V	17 ADMIN. SAL.- A. SALTZMAN		QUALITY CARE MANAGEMENT	100.00%	21,661	21,661
21	V	17 ADMIN. SAL - B BENOUDIZ		QUALITY CARE MANAGEMENT	100.00%	20,879	20,879
22	V	17 ADMIN. SAL. - B. CLOCH		QUALITY CARE MANAGEMENT	100.00%	52,362	52,362
23	V	17 ADMIN. SAL. - B. TEITELBAUM		QUALITY CARE MANAGEMENT	100.00%	5,697	5,697
24	V	17 ADMIN. SAL. - J. MEISELS		QUALITY CARE MANAGEMENT	100.00%	2,344	2,344
25	V	17 ADMIN. SAL. - MIKE FILIPPO		QUALITY CARE MANAGEMENT	100.00%	16,961	16,961
26	V	19 PROFESSIONAL FEES		QUALITY CARE MANAGEMENT	100.00%	3,696	3,696
27	V	20 FEES,SUBSCRIPTIONS		QUALITY CARE MANAGEMENT	100.00%	3,914	3,914
28	V	21 CLERICAL & GENERAL		QUALITY CARE MANAGEMENT	100.00%	129,088	129,088
29	V	24 EDUCATION & SEMINAR		QUALITY CARE MANAGEMENT	100.00%	670	670
30	V	25 OTHER ADMIN. STAFF TRANS.		QUALITY CARE MANAGEMENT	100.00%	2,059	2,059
31	V	26 INSURANCE		QUALITY CARE MANAGEMENT	100.00%	81	81
32	V	27 EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	33,979	33,979
33	V	30 DEPRECIATION		QUALITY CARE MANAGEMENT	100.00%	24,729	24,729
34	V	32 INTEREST		QUALITY CARE MANAGEMENT	100.00%	6,317	6,317
35	V	34 OFFICE RENT-UNRELATED		QUALITY CARE MANAGEMENT	100.00%	13,374	13,374
36	V	35 EQUIPMENT RENTAL		QUALITY CARE MANAGEMENT	100.00%	1,606	1,606
37	V						
38	V	19 CORPORATE ALLOCATION	406,945	QUALITY CARE MANAGEMENT	100.00%		(406,945)
39	Total		\$ 406,945			\$ 381,515	\$ * (25,430)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8	
Schedule V	Line	Cost Per General Ledger Item	Amount	Cost to Related Organization Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	REPAIRS AND MAINT.	\$ 3,900	QUALITY CARE MANAGEMENT	100.00%	\$ 9,989	\$ 6,089
16	V	7	EMP. BEN.-GEN. SERV.		QUALITY CARE MANAGEMENT	100.00%	1,604	1,604
17	V							
18	V	1	DIETICIAN SALARIES	4,320	QUALITY CARE MANAGEMENT	100.00%	4,683	363
19	V	7	EMP. BEN.-GEN. ADMIN.		QUALITY CARE MANAGEMENT	100.00%	752	752
20	V							
21	V							
22	V							
23	V							
24	V							
25	V							
26	V							
27	V							
28	V							
29	V							
30	V							
31	V							
32	V							
33	V							
34	V							
35	V							
36	V							
37	V							
38	V							
39	Total		\$ 8,220			\$ 17,028	\$ *	8,808

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	10A REHAB CONSULTING	\$ 8,556	ADVANCED THERAPY & REHAB, L.L.C.	100.00%	\$ 7,110	\$ (1,446)	15
16	V	39 ANCILLARY REHAB	367,551	ADVANCED THERAPY & REHAB, L.L.C.	100.00%	305,435	(62,116)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 376,107			\$ 312,545	\$ * (63,562)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 MEDICAL/TUBE FEED-MDCR	\$ 13,848	QUALITY CARE MEDICAL SUPPLY	100.00%	\$ 5,091	\$ (8,757)	15
16	V	10 MEDICAL SUPPLIES	38,575	QUALITY CARE MEDICAL SUPPLY	100.00%	4,254	(34,321)	16
17	V	1 FOOD SUPPLEMENTS		QUALITY CARE MEDICAL SUPPLY	100.00%	9,926	9,926	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 52,423			\$ 19,271	\$ * (33,152)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V			\$			\$	\$	15	
16	V								16	
17	V								17	
18	V								18	
19	V								19	
20	V								20	
21	V								21	
22	V								22	
23	V								23	
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			\$				\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount		Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization		
15	V		\$					\$		15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total		\$					\$ 0	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	0 \$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DAVIS MEISELS	ADMIN CONSULT	ADMINISTRATIVE	50.00	SEE ATTACHED	7.5	14.00	EXEC MGMT	\$ 60,000	17-3	1
2	DAVID MEISELS	EXEC ADMIN	ADMINISTRATIVE		SEE ATTACHED	7.5	14.00	SALARIES	97,533	17-1	2
3	BRUCHA TEITELBAUM		ADMINISTRATIVE		SEE ATTACHED	0.8	2.00	ALLOC.QCM	5,697	17-7	3
4	JOSEPH MEISELS		ADMINISTRATIVE		SEE ATTACHED	3.5	7.00	ALLOC.QCM	13,958	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 177,188		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CEN # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

Fax Number (\_\_\_\_\_) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CEN # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization QUALITY CARE MANAGEMENT  
 Street Address 8950 GROSS POINT RD. #E  
 City / State / Zip Code SKOKIE, IL. 60077  
 Phone Number ( 847) 663-1155  
 Fax Number ( 847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	352,747	6	\$ 9,193	\$	59,233	\$ 1,544	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	352,747	6	3,145		59,233	528	2
3	10	SAL-NURSING	PATIENT DAYS	352,747	6	177,703	177,703	59,233	29,840	3
4	15	EMP. BEN.-H.C.	PATIENT DAYS	352,747	6	28,527		59,233	4,790	4
5	17	ADMIN SAL-NON-OWNER	PATIENT DAYS	352,747	6	32,137	32,137	59,233	5,396	5
6	17	ADMIN. SAL.- A. SALTZMAN	PATIENT DAYS	352,747	6	128,995	128,995	59,233	21,661	6
7	17	ADMIN. SAL - B BENOUDIZ	PATIENT DAYS	352,747	6	124,342	124,342	59,233	20,879	7
8	17	ADMIN. SAL. - B. CLOCH	PATIENT DAYS	352,747	6	311,829	311,829	59,233	52,362	8
9	17	ADMIN. SAL. - B. TEITELBAUM	PATIENT DAYS	352,747	6	33,925	33,925	59,233	5,697	9
10	17	ADMIN. SAL - J. MEISELS	PATIENT DAYS	352,747	6	13,958	13,958	59,233	2,344	10
11	17	ADMIN. SAL. - MIKE FILIPPO	PATIENT DAYS	352,747	6	101,006	101,006	59,233	16,961	11
12	19	PROFESSIONAL FEES	PATIENT DAYS	352,747	6	22,013		59,233	3,696	12
13	20	FEES,SUBSCRIPTIONS	PATIENT DAYS	352,747	6	23,307		59,233	3,914	13
14	21	CLERICAL & GENERAL	PATIENT DAYS	352,747	6	768,752	651,494	59,233	129,088	14
15	24	EDUCATION & SEMINAR	PATIENT DAYS	352,747	6	3,989		59,233	670	15
16	25	OTHER ADMIN. STAFF TRANS	PATIENT DAYS	352,747	6	12,263		59,233	2,059	16
17	26	INSURANCE	PATIENT DAYS	352,747	6	485		59,233	81	17
18	27	EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	352,747	6	202,353		59,233	33,979	18
19	30	DEPRECIATION	PATIENT DAYS	352,747	6	147,266		59,233	24,729	19
20	32	INTEREST	PATIENT DAYS	352,747	6	37,619		59,233	6,317	20
21	34	OFFICE RENT-UNRELATED	PATIENT DAYS	352,747	6	79,644		59,233	13,374	21
22	35	EQUIPMENT RENTAL	PATIENT DAYS	352,747	6	9,564		59,233	1,606	22
23										23
24										24
25	TOTALS					\$ 2,272,015	\$ 1,575,389		\$ 381,515	25

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CEN # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization QUALITY CARE MANAGEMENT  
 Street Address 8950 GROSS POINT RD. #E  
 City / State / Zip Code SKOKIE, IL. 60077  
 Phone Number ( 847) 663-1155  
 Fax Number ( 847) 663-0917

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	REPAIRS AND MAINT.	PAINTING REVENUE	21,912	5	\$ 56,124	\$ 56,124	3,900	\$ 9,989	1
2	7	EMP. BEN.-GEN. SERV.	PAINTING REVENUE	21,912	5	9,010		3,900	1,604	2
3										3
4	1	DIETICIAN SALARIES	DIETICIAN REVENUE	18,893	6	20,480	20,480	4,320	4,683	4
5	7	EMP. BEN.-GEN. ADMIN.	DIETICIAN REVENUE	18,893	6	\$ 3,288	\$	4,320	\$ 752	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 88,902	\$ 76,604		\$ 17,028	25

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CEN # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Advanced Therapy & Rehab., L.L.C.  
 Street Address 8950 Gross Point Rd. #E  
 City / State / Zip Code Skokie, IL 60077  
 Phone Number ( 847)663-1155  
 Fax Number ( 847)663-0917

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	10A	REHAB CONSULTING	DIRECT ALLOCATION					7,110	1
2	39	ANCILLARY REHAB	DIRECT ALLOCATION					305,435	2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 312,545	25

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CEN # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Quality Care Medical Supply  
 Street Address 8950 Gross Point Rd. #E  
 City / State / Zip Code Skokie, IL 60077  
 Phone Number (847)663-1155  
 Fax Number (847)663-0917

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL/TUBE FEED-MDCR	DIRECT ALLOCATION					5,091	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION					4,254	2
3	1	FOOD SUPPLEMENTS	DIRECT ALLOCATION					9,926	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 19,271	25

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CEN # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CEN # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CEN # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CEN # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CEN # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_

Street Address \_\_\_\_\_

City / State / Zip Code \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number AMBASSADOR NURSING & REHABILIT/ # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

## IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Boatman's Mortgage		X	Mortgage	\$14,446.00		\$ 1,970,600	\$ 1,549,360	10/1/17	8.5000	\$ 133,270	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Corus Bank		X	Line of Credit	Interest Only		1,000,000	1,000,000		Prime=1/2	99,222	6	
7	Cole Taylor Bank		X	Working Capital	Interest Only		100,000		12/00		5,792	7	
8	Hill Rom		X	Equipment Purchase	\$785.00		8,927	3,828	05/01	10.0000	395	8	
9	TOTAL Facility Related				\$15,231.00		\$ 3,079,527	\$ 2,553,188			\$ 238,679	9	
	B. Non-Facility Related*												
10	Supplemental Schedule											10	
11	INTEREST INCOME										(3,320)	11	
12	ALLOC-QUALITY CARE										6,317	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 2,997	14	
15	TOTALS (line 9+line14)						\$ 3,079,527	\$ 2,553,188			\$ 241,676	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Facility Name & ID Number AMBASSADOR NURSING & REHABILITAT# 0004077

Report Period Beginning:

01/01/00

Ending:

12/31/00**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6	7	8	9	10
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO				Original	Balance			
1							\$	\$			\$
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21							\$	\$			\$

Facility Name & ID Number **AMBASSADOR NURSING & REHABILITATION CENTER, INC.**# **0004077**

Report Period Beginning:

**01/01/00**

Ending:

**12/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$	<b>216,000</b>	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	<b>208,047</b>	2
3. Under or (over) accrual (line 2 minus line 1).	\$	<b>(7,953)</b>	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	<b>215,000</b>	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	<b>207,047</b>	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	<b>225,889</b>	8
	1996	<b>231,447</b>	9
	1997	<b>205,799</b>	10
	1998	<b>209,453</b>	11
	1999	<b>208,047</b>	12

<b>FOR OHF USE ONLY</b>			
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

**1999 ACTUAL \$208,047 X 1.03 = \$215,000 ROUNDED**

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

Facility Name &amp; ID Number AMBASSADOR NURSING &amp; REHABILITATION CENTER, INC.

# 0004077

Report Period Beginning:

01/01/00

Ending:

12/31/00

**X. BUILDING AND GENERAL INFORMATION:**A. Square Feet: 40,497 B. General Construction Type: Exterior BRICK Frame \_\_\_\_\_ Number of Stories THREEC. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONEF. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO  
If so, please complete the following:1. Total Amount Incurred: 176,304 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_3. Current Period Amortization: 9,362 4. Dates Incurred: \_\_\_\_\_Nature of Costs: MORTGAGE COSTS

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>FACILITY</u>		<u>1977</u>	\$ <u>127,394</u>	1
2					2
3	<b>TOTALS</b>			\$ <u>127,394</u>	3

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	190		1977	1977	\$ 1,714,426	\$ 57,148	35	\$ 57,148	\$	\$ 1,342,971	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1980	3,109		20			3,109	9
10	Various			1981	7,984		20			7,984	10
11	Various			1983	820		20			820	11
12	Various			1984	11,000		20			11,000	12
13	Various			1986	44,252	2,301	20	2,329	28	32,939	13
14	Various			1987	5,800	184	20	290	106	3,915	14
15	Various			1988	1,825	58	20	58		715	15
16	Various			1990	48,352	1,535	20	1,708	173	17,535	16
17	Various			1991	1,571	93	20	79	(14)	731	17
18	Various			1992	8,653	345	20	432	87	3,634	18
19	Various			1993	55,217	591	20	2,761	2,170	25,409	19
20	Various			1994	8,007	31	20	401	370	2,329	20
21	Various			1995	35,063	899	20	1,753	854	9,372	21
22	CONSTRUCTION			1996	4,405	113	20	220	107	1,008	22
23	ELECTRICAL-CARY			1996	1,206	31	20	60	29	280	23
24											24
25											25
26											26
27											27
28											28
29											29
30	PAGE 12F TOTALS				15,628	9		325	316	325	30
31	PAGE 12E TOTALS				72,790	1,750		1,982	232	2,051	31
32	PAGE 12D TOTALS				77,663	1,821		3,883	2,062	5,552	32
33	PAGE 12C TOTALS				123,448	1,673		6,172	4,499	11,362	33
34	PAGE 12B TOTALS				102,508	3,826		5,127	1,301	13,418	34
35	PAGE 12A TOTALS				112,509	2,695		5,626	2,931	25,748	35
36	TOTAL (lines 4 thru 35)				\$ 2,456,236	\$ 75,103		\$ 90,354	\$ 15,251	\$ 1,522,207	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	WATER METER			1996	1,765	45	20	88	43	396	9
10	AIR CONDITIONING			1996	71,420	1,831	20	3,571	1,740	16,367	10
11	DUCTWORK			1996	1,200	31	20	60	29	285	11
12	CONDENSER REPAIR			1996	1,071	27	20	54	27	252	12
13	LOBBY REMODEL			1996	4,521	116	20	226	110	1,055	13
14	BUILDING REPAIRS			1996	2,500	64	20	125	61	573	14
15	BOOSTER HTR REPAIR			1996	543	14	20	27	13	124	15
16	ABACE ELECTRIC			1996	600	15	20	30	15	150	16
17	NURSE STATION			1996	5,317	136	20	266	130	1,219	17
18	BORDERS & CENTERS			1996	2,381	61	20	119	58	526	18
19	SECURITY DOORS			1996	2,996	77	20	150	73	687	19
20	KITCHEN PLUMBING			1996	1,532	39	20	77	38	353	20
21	PUMP REPAIRS			1996	847	22	20	42	20	192	21
22	INSULATION			1996	879	23	20	44	21	194	22
23	PAINTING & DEC,			1996	3,073	77	20	154	73	706	23
24	PUMP MOTOR			1996	620	16	20	31	15	142	24
25	ELECTRICAL WORK			1996	1,277	33	20	64	31	288	25
26	LIGHTS			1996	1,090	28	20	55	27	243	26
27	DOOR SECURITY SYST.			1996	647	17	20	32	15	144	27
28	BEARING ASSEMBLY			1996	585	15	20	29	14	128	28
29	COOLING TWR REPAIRS			1996	860	22	20	43	21	194	29
30	WINDOWS			1996	599	15	20	30	15	132	30
31	TELEPHONES			1996	940		20	47	47	215	31
32	BLINDS			1996	664	17	20	33	16	143	32
33	CARPET			1996	1,217	31	20	61	30	264	33
34	SECURITY CAMERA			1996	1,564		20	78	78	364	34
35	TELEPHONES			1996	1,801		20	90	90	412	35
36	TOTAL (lines 4 thru 35)				\$ 112,509	\$ 2,695		\$ 5,626	\$ 2,931	\$ 25,748	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>FLOOD LIGHTS</b>			1996	840	22	20	42	20	206	9
10	<b>DOOR SECURITY SYS</b>			1996	1,474	38	20	74	36	333	10
11	<b>ELEVATOR WORK</b>			1997	1,528	39	20	76	37	285	11
12	<b>PIPES</b>			1997	1,600	41	20	80	39	242	12
13	<b>ELEVATOR WORK</b>			1997	2,900	74	20	145	71	532	13
14	<b>ROOM SIGNS</b>			1997	1,043		20	52	52	104	14
15	<b>HAND RAILS</b>			1997	3,743	96	20	187	91	701	15
16	<b>ELEVATOR WORK</b>			1997	1,850	47	20	93	46	357	16
17	<b>BATHROOM FIXTURE</b>			1997	956		20	48	48	96	17
18	<b>AIR HANDLER REPAIR</b>			1997	2,250	58	20	113	55	396	18
19	<b>DUCT WORK</b>			1997	1,104	28	20	55	27	193	19
20	<b>DOOR ALARMS</b>			1997	979	25	20	49	24	167	20
21	<b>SEAL COATING</b>			1997	1,550	40	20	78	38	260	21
22	<b>FIRE DAMPERS</b>			1997	10,420	267	20	521	254	1,693	22
23	<b>GENERATOR REPAIR</b>			1997	2,055	53	20	103	50	326	23
24	<b>WALLPAPER</b>			1997	3,024	78	20	151	73	591	24
25	<b>ELEVATOR WORK</b>			1997	2,038	52	20	102	50	374	25
26	<b>GAS LINE FOR OVENS</b>			1998	1,574		20	79	79	158	26
27	<b>LOCK</b>			1998	1,909		20	95	95	190	27
28	<b>MASTER KEY SYSTEM</b>			1998	1,280		20	64	64	128	28
29	<b>THERMO TECH</b>			1998	1,097	28	20	55	27	160	29
30	<b>SPRINKLER SYSTEM</b>			1998	1,175		20	59	59	118	30
31	<b>SPRINKLER SYSTEM</b>			1998	688		20	34	34	68	31
32	<b>NURSE CALL SYSTEM</b>			1998	576		20	29	29	58	32
33	<b>ELEC WIRING</b>			1998	685		20	34	34	68	33
34	<b>ROOF REPLACEMENT</b>			1998	47,000	1,205	20	2,350	1,145	4,896	34
35	<b>SECURITY CAMERA</b>			1998	7,170	1,635	20	359	(1,276)	718	35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 102,508	\$ 3,826		\$ 5,127	\$ 1,301	\$ 13,418	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9		<b>FIRE DAMPERS</b>		1998	21,000	538	20	1,050	512	3,063	9
10		<b>PAINTING &amp; DECORATIN</b>		1998	9,169		20	458	458	916	10
11		<b>Z.WALLACH</b>		1998	1,968	50	20	98	48	270	11
12		<b>WIRING</b>		1998	1,644	42	20	82	40	226	12
13		<b>CRANK HANDLES</b>		1998	765		20	38	38	76	13
14		<b>HOT WTR REPAIRS</b>		1998	3,917	100	20	196	96	408	14
15		<b>THERAPY RM CONSTRUC.</b>		1998	6,800	174	20	340	166	653	15
16		<b>CARPET INSTALL</b>		1998	4,856	125	20	243	118	506	16
17		<b>THER ROOM WINDOW</b>		1998	900	23	20	45	22	101	17
18		<b>PLUMBING INSTALL</b>		1998	2,600	67	20	130	63	271	18
19		<b>ELEVATOR DOOR</b>		1998	2,000	51	20	100	49	242	19
20		<b>WALLPAPER</b>		1998	3,140	81	20	157	76	379	20
21		<b>PUMP</b>		1998	2,099	54	20	105	51	254	21
22		<b>PIPES</b>		1998	1,100	28	20	55	27	165	22
23		<b>ROOF TOP EXHAUST R&amp;M</b>		1998	2,562	66	20	128	62	373	23
24		<b>SHED</b>		1999	2,847	73	20	142	69	213	24
25		<b>5-FANS</b>		1999	1,675		20	84	84	133	25
26		<b>ELECTCL BOX &amp; WIRE</b>		1999	1,808		20	90	90	113	26
27		<b>SPRINKLER</b>		1999	1,352		20	68	68	79	27
28		<b>DRAPERIES</b>		1999	27,981		20	1,399	1,399	1,520	28
29		<b>PAINTING &amp; DECORAT</b>		1999	14,612		20	731	731	792	29
30		<b>INST HANDRAILS</b>		1999	520	13	20	26	13	30	30
31		<b>FIRE DOORS</b>		1999	2,702	69	20	135	66	180	31
32		<b>INSTALL SINK</b>		1999	850	22	20	43	21	65	32
33		<b>ELECTRIC SERV</b>		1999	800		20	40	40	50	33
34		<b>HOT WATER VALVE</b>		1999	1,964	50	20	98	48	147	34
35		<b>EX FANS &amp; MOTORS</b>		1999	1,817	47	20	91	44	137	35
36		<b>TOTAL (lines 4 thru 35)</b>			\$ 123,448	\$ 1,673		\$ 6,172	\$ 4,499	\$ 11,362	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>FLOORING</b>			1999	21,896	561	20	1,095	534	1,278	9
10	<b>GATES</b>			1999	1,056	27	20	53	26	75	10
11	<b>INST HANDRAILS</b>			1999	1,600	41	20	80	39	107	11
12	<b>HANDRAILS</b>			1999	3,226	83	20	161	78	215	12
13	<b>HANDRAILS</b>			1999	8,652	222	20	433	211	577	13
14	<b>WALLPAPER</b>			1999	5,943	152	20	297	145	396	14
15	<b>CEILING TILE</b>			1999	1,706	44	20	85	41	113	15
16	<b>VACUUM BRKRS/LDRYRM</b>			1999	777	20	20	39	19	62	16
17	<b>HOT WATER PUMP</b>			1999	1,111	28	20	56	28	70	17
18	<b>FIRE PROOFING</b>			1999	3,200	82	20	160	78	320	18
19	<b>FIRE DOOR</b>			1999	1,120	29	20	56	27	98	19
20	<b>ELEV FLOORING</b>			1999	1,161	30	20	58	28	87	20
21	<b>DIESEL REHAB</b>			1999	1,600		20	80	80	120	21
22	<b>EXHAUST FAN PARTS</b>			1999	2,562	66	20	128	62	213	22
23	<b>VACUUM BRKRS/KITCHEN</b>			1999	864	22	20	43	21	68	23
24	<b>HEATING WORK</b>			1999	2,117	54	20	106	52	212	24
25	<b>OVERHEAD DOOR</b>			1999	4,160	107	20	208	101	329	25
26	<b>DOOR DETECTOR</b>			1999	1,975	51	20	99	48	198	26
27	<b>FIRE ALARM WORK</b>			1999	1,825	47	20	91	44	182	27
28	<b>DOOR CHECKS</b>			1999	1,584		20	79	79	105	28
29	<b>BOILER REHAB</b>			1999	1,605		20	80	80	113	29
30	<b>ELEV WORK</b>			1999	1,929	49	20	96	47	184	30
31	<b>NURSING CALL SYS</b>			1999	598		20	30	30	43	31
32	<b>WIRING</b>			1999	1,741	45	20	87	42	123	32
33	<b>DOUBLE DOORS</b>			1999	1,275		20	64	64	80	33
34	<b>WIRING</b>			1999	1,225	31	20	61	30	97	34
35	<b>FLOORING</b>			1999	1,155	30	20	58	28	87	35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 77,663	\$ 1,821		\$ 3,883	\$ 2,062	\$ 5,552	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	<b>PUMP &amp; TANK SYSTEM</b>			1999	1,562	40	20	78	38	98	9
10	<b>FENCE</b>			1999	580	15	20	29	14	58	10
11	<b>SINK</b>			1999	702	18	20	35	17	55	11
12	<b>CHILLER REPAIR</b>			2000	3,903	38	20	38		38	12
13	<b>FIRE SYSTEM HORN</b>			2000	700	140	20	140		140	13
14	<b>FENCE</b>			2000	2,644	132	20	132		132	14
15	<b>RANDEL ELECT</b>			2000	16,761	340	20	340		340	15
16	<b>FENCE</b>			2000	2,613	131	20	131		131	16
17	<b>WIRING</b>			2000	23,500	477	20	477		477	17
18	<b>SMOKE DETECTORS</b>			2000	1,817	37	20	37		37	18
19	<b>FENCE</b>			2000	988	50	20	50		50	19
20	<b>SMOKE DETECTORS</b>			2000	1,224	245	20	245		245	20
21	<b>WALK-IN FREEER</b>			2000	521		20	20	20	20	21
22	<b>ROOM SIGNS</b>			2000	1,695	27	20	27		27	22
23	<b>LAWN FAUCETS</b>			2000	1,557	12	20	12		12	23
24	<b>CITY SCREEN</b>			2000	1,068	8	20	8		8	24
25	<b>PLUMBING</b>			2000	1,196	6	20	6		6	25
26	<b>WATER LINE</b>			2000	809	4	20	4		4	26
27	<b>URINALS</b>			2000	612	5	20	5		5	27
28	<b>RANDEL</b>			2000	1,030	1	20	1		1	28
29	<b>FIREPROOF WALLS</b>			2000	550		20	23	23	23	29
30	<b>FAN MOTOR</b>			2000	1,276		20	32	32	32	30
31	<b>TOILET</b>			2000	698		20	32	32	32	31
32	<b>FIRE ALARM</b>			2000	528		20	9	9	9	32
33	<b>REPAIR SUN PORCH</b>			2000	2,500	24	20	24		24	33
34	<b>LOCKS</b>			2000	550		20	7	7	7	34
35	<b>PLUMBING</b>			2000	1,206		20	40	40	40	35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 72,790	\$ 1,750		\$ 1,982	\$ 232	\$ 2,051	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	PLUMBING		2000		1,101		20	37	37	37	9
10	PLUMBING		2000		932		20	35	35	35	10
11	PAINTING & DECOR		2000		993		20	25	25	25	11
12	GFI RECEPTACLE		2000		657		20	8	8	8	12
13	SPRINKLER		2000		713		20	6	6	6	13
14	DOORS		2000		965		20	32	32	32	14
15	PLUMBING		2000		1,191		20	10	10	10	15
16	A/C		2000		900	9	20	9		9	16
17	PLUMBING		2000		807		20	10	10	10	17
18	SPRINKLERS		2000		535		20	16	16	16	18
19	ELECTRICAL		2000		519		20	9	9	9	19
20	FAUCETS		2000		1,101		20	18	18	18	20
21	PLUMBING		2000		847		20	18	18	18	21
22	SPRINKLER		2000		1,225		20	31	31	31	22
23	FAN COIL		2000		953		20	24	24	24	23
24	TOWER FAN		2000		1,016		20	25	25	25	24
25	PLUMBING		2000		503		20	4	4	4	25
26	DOORS		2000		670		20	8	8	8	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 15,628	\$ 9		\$ 325	\$ 316	\$ 325	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10												9
11												10
12												11
13												12
14												13
15												14
16												15
17												16
18												17
19												18
20												19
21												20
22												21
23												22
24												23
25												24
26												25
27												26
28												27
29												28
30												29
31												30
32												31
33												32
34												33
35												34
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	35	
											36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$	\$	\$	4	
5											5	
6											6	
7											7	
8											8	
9	Improvement Type**											
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$		\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION CENTER, INC. # 0004077 Report Period Beginning: 01/01/00 Ending: 12/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4					\$	\$		\$		\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9											9	
10											10	
11											11	
12											12	
13											13	
14											14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36	TOTAL (lines 4 thru 35)				\$	\$		\$	\$	\$	36	

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number AMBASSADOR NURSING & REHABILITATION # 0004077

Report Period Beginning:

01/01/00

Ending:

12/31/00

**XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 461,907	\$ 71,760	\$ 42,457	\$ (29,303)		\$ 171,789	37
38	Current Year Purchases	114,480	21,036	21,097	61		21,097	38
39	Fully Depreciated Assets	450,728	16,239	1,833	(14,406)		223,146	39
40								40
41	<b>TOTALS</b>	\$ 1,027,115	\$ 109,035	\$ 65,387	\$ (43,648)		\$ 416,032	41

**D. Vehicle Depreciation (See instructions.)\***

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	<b>TOTALS</b>			\$	\$	\$	\$		\$	46

**E. Summary of Care-Related Assets**

	1	2	
	Reference	Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 3,610,745	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 184,138	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 155,741	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (28,397)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,938,239	51

\*\*

**F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)**

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	<b>TOTALS</b>	\$	\$	\$	57

**G. Construction-in-Progress**

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

AMBASSADOR NURSING & REHABILITATION CENTER, INC.  
0004077  
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE  
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
<b>LINE 28: PRIOR YEARS</b>					
AMBASSADOR NURSING & REHAB CENTER, INC.	381,793	47,329	34,445	(12,884)	157,303
BUILDING PARTNERSHIP					
QUALITY CARE	80,114	24,431	8,012	(16,419)	14,486
TOTALS	461,907	71,760	42,457	(29,303)	171,789

**LINE 29: CURRENT YEAR**

AMBASSADOR NURSING & REHAB CENTER, INC.	112,381	20,738	21,019	281	21,019
BUILDING PARTNERSHIP					
QUALITY CARE	2,099	298	78	(220)	78
TOTALS	114,480	21,036	21,097	61	21,097

**LINE 30: FULLY DEPRECIATED**

AMBASSADOR NURSING & REHAB CENTER, INC.	223,146	16,239	1,833	(14,406)	223,146
BUILDING PARTNERSHIP	227,582				
QUALITY CARE					
TOTALS	450,728	16,239	1,833	(14,406)	223,146

**TOTALS (Should Tie to Totals on Page 13)**

AMBASSADOR NURSING & REHAB CENTER, INC.	717,320	84,306	57,297	(27,009)	401,468
BUILDING PARTNERSHIP	227,582				
QUALITY CARE	82,213	24,729	8,090	(16,639)	14,564
TOTALS	1,027,115	109,035	65,387	(43,648)	416,032

<b>Facility Name &amp; ID Number</b>	<b>AMBASSADOR NURSING &amp; REHABILITATION CENT #</b>	<b>0004077</b>	<b>Report Period Beginning:</b>	<b>01/01/00</b>	<b>Ending:</b>	<b>12/31/00</b>
--------------------------------------	---	----------------	---------------------------------	-----------------	----------------	-----------------

## XII. RENTAL COSTS

**A. Building and Fixed Equipment (See instructions.)**

**1. Name of Party Holding Lease:** N/A

**2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?**

**If NO, see instructions.**

☒ YES      ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	ALLOC QUALITY CARE				13,374			5
6								6
7	TOTAL				\$ 13,374			7

**8. List separately any amortization of lease expense included on page 4, line 34.**

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_\*

**B. Equipment-Excluding Transportation and Fixed Equipment.** (See instructions.)

**15. Is Movable equipment rental included in building rental?**

☐ YES      ☐ NO

16. Rental Amount for movable equipment: \$ 19,741 Description: COPIER=\$14,956, ICEMAKER=\$1,020, WATER SYS=\$2,159, ALLOC QCM=\$1,606  
(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$		17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	0	21

**10. Effective dates of current rental agreement:**

## Beginning

**Ending**

**11. Rent to be paid in future years under the current rental agreement:**

Fiscal Year Ending	Annual Rent
--------------------	-------------

12.                      /2001 §                     

13.                      /2002 \$                     

14.                      /2003 \$                     

**\* If there is an option to buy the building, please provide complete details on attached schedule.**

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

Facility Name & ID Number      AMBASSADOR NURSING & REHABILITATION CENTER, INC.      #      0004077      Report Period Beginning:      01/01/00      Ending:      12/31/00  
 XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input checked="checked" type="checkbox"/> YES <input type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE      _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE      _____
---	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		360		360
9	TOTALS	\$	\$ 360	\$	\$ 360
10	SUM OF line 9, col. 1 and 2 (e)	\$ 360			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

## XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 10,265	\$		\$ 10,265	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			7,866			7,866	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			367,741			367,741	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				70,404		70,404	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**SEE SUPPLEMENTAL Other (specify): SCHEDULE**	39-3, 39-2				228	67,844		68,072	13
14	TOTAL			\$		\$ 386,100	\$ 138,248	\$	524,348	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

<u>Special Services - Supplies (Column 6 - Other)</u>	<u>Amount</u>
1 RESPIRATORY THERAPY SUPPLIES	9,492
2 AIR FLUIZED BEDS	19,176
3 OXYGEN	18,012
4 LABORATORY	6,088
5 IV THERAPY	1,000
6 TUBE FEEDING	13,848
7 MEDICAL SUPPLIES	228
8	
9	
10	

67,844

<u>Outside Therapies (Column 5 - Other)</u>	<u>Amount</u>
1 RESPIRATORY THERAPY	228
2	
3	
4	
5	
6	
7	
8	
9	
10	

228

## STATE OF ILLINOIS

Page 17

Facility Name & ID Number      AMBASSADOR NURSING & REHABILITATION CENT#      0004077      Report Period Beginning:      01/01/00      Ending:      12/31/00  
 XV. BALANCE SHEET - Unrestricted Operating Fund.      As of      12/31/00      (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 300	\$ 300	1
2	Cash-Patient Deposits	63,142	63,142	2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,575,851	1,575,851	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	56,577	56,577	6
7	Other Prepaid Expenses	18,703	18,703	7
8	Accounts Receivable (owners or related parties)		10,436	8
9	Other(specify): <a href="#">See supplemental schedule</a>	307,674	307,674	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,022,247	\$ 2,032,683	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		127,394	13
14	Buildings, at Historical Cost		1,725,519	14
15	Leasehold Improvements, at Historical Cos	581,601	809,183	15
16	Equipment, at Historical Cost	743,890	743,890	16
17	Accumulated Depreciation (book methods)	(657,014)	(2,238,587)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	1,667	177,971	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(102,510)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See supplemental schedule</a>			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 670,144	\$ 1,242,860	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,692,391	\$ 3,275,543	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,021,012	\$ 1,260,997	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	63,406	63,406	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	52,812	52,812	30
31	Accrued Taxes Payable (excluding real estate taxes)	12,274	12,274	31
32	Accrued Real Estate Taxes(Sch.IX-B)	215,000	215,000	32
33	Accrued Interest Payable		10,974	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See supplemental schedule</a>	312,286	440,871	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,676,790	\$ 2,056,334	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,003,828	1,003,828	39
40	Mortgage Payable		1,549,360	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See supplemental schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 1,003,828	\$ 2,553,188	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,680,618	\$ 4,609,522	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 11,773	\$ #REF!	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,692,391	\$ #REF!	48

\*(See instructions.)

## STATE OF ILLINOIS

Page 17 SUPP-1

Facility Name &amp; ID Number AMBASSADOR NURSING &amp; REHABILITATION CEN# 0004077

Report Period Beginning: 01/01/00

Ending:

12/31/00

## SUPPLEMENTAL SCHEDULE OF OTHER ASSETS &amp; LIABILITIES

As of 12/31/00

## OTHER CURRENT ASSETS:

	Amount	Amount
Real Estate Tax Escrow	125,488	125,488
Due from Building	128,585	128,585
Foreign Nurse Advances	27,000	27,000
Employee Advances	26,601	26,601

<u>307,674</u>	<u>307,674</u>
----------------	----------------

## OTHER NON CURRENT ASSETS:

<u>                    </u>	<u>                    </u>
<u>                    </u>	<u>                    </u>

## OTHER CURRENT LIABILITIES:

	Amount	Amount
Due to Others	37,286	37,286
Due to Continental Care	275,000	275,000
Due to Ambassador Nursing Center, Inc.		128,585

<u>312,286</u>	<u>440,871</u>
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## OTHER NON CURRENT LIABILITIES:

<u>                    </u>	<u>                    </u>
<u>                    </u>	<u>                    </u>

Facility Name & ID Number	AMBASSADOR NURSING & REHAB #	0004077	Report Period Beginning:	01/01/00	Ending:	12/31/00
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Balance per General Ledger	345,632
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Adjustments:

-

-

-

Rent Expense	150,000
--------------	---------

Total adjustments	150,000
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Balance - Beginning of Year	495,632
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Equity(Deficit) from Page 17 Col 1	11,773
------------------------------------	--------

Related Party

Equity(Deficit)	-1320162
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Income	-25590
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(1,345,752)
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Combined Equity - End of Year	(1,333,979)
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**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 495,632</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<a href="#">Schedule attached</a>	<b>(150,000)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 345,632</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(333,859)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (333,859)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 11,773</b>	<b>24</b>

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number AMBASSADOR NURSING &amp; REHABILITATION # 0004077 Report Period Beginning: 01/01/00

Ending: 12/31/00

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,905,212	1
2	Discounts and Allowances for all Levels	(1,025,336)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 5,879,876	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	740,917	6
7	Oxygen	29,040	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 769,957	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	102,411	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,005	19
20	Radiology and X-Ray		20
21	Other Medical Services	68,471	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 182,887	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	3,320	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 3,320	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<a href="#">See supplemental schedule</a>	22,258	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 22,258	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,858,298	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,249,102	31
32	Health Care	2,675,865	32
33	General Administration	2,027,196	33
	<b>B. Capital Expense</b>		
34	Ownership	611,336	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	524,348	35
36	Provider Participation Fee	104,310	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,192,157	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(333,859)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (333,859)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? [not complete](#) If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

## DESCRIPTION

AMOUNT

1	Vending Commissions	300
2	Income from Power Outage - Net of Expenses	21,958
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		

TOTALS	22,258
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Facility Name & ID Number **AMBASSADOR NURSING & REHABILITATION CENTE**# **0004077**Report Period Beginning: **01/01/00**

Ending:

**12/31/00****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,022	2,175	\$ 58,759	\$ 27.02	1
2	Assistant Director of Nursing	728	768	19,129	24.91	2
3	Registered Nurses	23,200	28,179	509,688	18.09	3
4	Licensed Practical Nurses	8,529	9,460	148,825	15.73	4
5	Nurse Aides & Orderlies	98,214	108,420	1,001,612	9.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,925	2,242	25,659	11.44	9
10	Activity Assistants	11,391	12,980	104,602	8.06	10
11	Social Service Workers	5,336	6,352	45,986	7.24	11
12	Dietician					12
13	Food Service Supervisor	1,932	2,147	31,737	14.78	13
14	Head Cook					14
15	Cook Helpers/Assistants	34,271	36,439	247,451	6.79	15
16	Dishwashers					16
17	Maintenance Workers	2,943	3,422	35,966	10.51	17
18	Housekeepers	30,976	32,267	198,494	6.15	18
19	Laundry	9,984	10,414	63,801	6.13	19
20	Administrator	1,929	2,618	67,447	25.76	20
21	Assistant Administrator	736	760	14,615	19.23	21
22	Other Administrative	2,753	2,813	106,403	37.83	22
23	Office Manager					23
24	Clerical	10,734	12,338	162,691	13.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,550	2,550	27,987	10.98	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	250,153	276,344	\$ 2,870,852 *	\$ 10.39	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

**B. CONSULTANT SERVICES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	500	\$ 17,638	1-3	35
36	Medical Director	44	1,650	9-3	36
37	Medical Records Consultant	104	4,160	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	204	8,160	10-3	39
40	Physical Therapy Consultant	133	6,001	10a-3	40
41	Occupational Therapy Consultant	88	3,984	10a-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	88	3,901	11-3	44
45	Social Service Consultant	77	3,876	12-3	45
46	Other(specify)				46
47	PARKINSONS CONSULTANT	120	6,000	12-3	47
48					48
49	TOTAL (lines 35 - 48)	1,358	\$ 55,370		49

**C. CONTRACT NURSES**

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	143	\$ 5,336	10-3	50
51	Licensed Practical Nurses	9,961	423,936	10-3	51
52	Nurse Aides	7,343	141,599	10-3	52
53	TOTAL (lines 50 - 52)	17,447	\$ 570,871		53



## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	%	Amount
Courtney VanLonHuyzen	Admin	0	\$ 67,496
500 AHN (8/00-12/00)	Asst. Admin	0	14,615
Paulette Hill (2/00-4/00)	Weekend Admin	0	1,128
Bernice Simpson (6/00-12/00)	Weekend Admin	0	7,693
David Meisels	Exec. Admin	50%	97,533
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 188,465
B. Administrative - Other			
Description			Amount
David Meisels Management Fees		\$	60,000
Quality Care Management Fees			3,310
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		\$	63,310
C. Professional Services			
Vendor/Payee	Type		Amount
Mary Carmen R. Madrid	Legal	\$	15,674
Holeb & Coff	Legal		3,242
Julie Katz	Legal		1,802
Roy B. Burgonio	Legal		10,500
Skefsky & Frolich	Legal		7,102
Youngae Kim	Legal		(1,495)
Sanchoff & Weaver	Legal		1,751
Winston& Strawn	Legal		363
E-Solutions	Computer Services		1,207
AccuMed	Computer Services		2,836
See Attached Schedule	See Attached Schedule		572,024
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)		\$	615,006
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	45,342
Unemployment Compensation Insurance			32,489
FICA Taxes			215,038
Employee Health Insurance			155,835
Employee Meals			41,548
Illinois Municipal Retirement Fund (IMRF)*			
Chicago Head Tax			4,862
Union Pension			21,715
401k			3,458
Other Employee Benefits			19,854
TOTAL (agree to Schedule V, line 22, col.8)		\$	540,141
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	200
Advertising: Employee Recruitment			22,951
Health Care Worker Background Check			930
(Indicate # of checks performed _____)			
Yellow Page Advertising			4,184
Promotional Advertising			54,396
Employee Recruitment			14,786
Dues and Subscriptions			8,825
Licenses & Fees			9,993
Allocated from QCM			3,914
Less: Public Relations Expense		(	
Non-allowable advertising			(54,396)
Yellow page advertising			(4,184)
TOTAL (agree to Sch. V, line 20, col. 8)		\$	61,599
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
In-State Travel			
Seminar Expense			3,070
Alloc. Quality Care			670
Entertainment Expense		(	
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	3,740

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**  
(See instructions.)

[illegible]

Facility Name & ID Number **AMBASSADOR NURSING & REHABILITATION CENTER, INC.** # **0004077** Report Period Beginning: **01/01/00** Ending: **12/31/00**

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ILCLTC - \$7,838
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,523 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 104,310  
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 41,548 Has any meal income been offset against related costs? N/A Indicate the amount. \$ N/A
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? N/A  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
**g. Does the facility transport residents to and from day training?** No  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.

Date: 07/17/2000

To: Administrator/Cost Report Preparer

From: Office of Health Finance

Re: 2000 Long Term Care Cost Report and Instructions on Diskette  
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to be entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

**WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.**

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "All Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

#### **Notes Applicable only to Lotus users**

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu bar after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use File-Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

#### **Notes Applicable only to Excel users**

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been sealed, you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can go to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/rw